Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FOUNDATION ANCILLARY SERVICES

Respondent Name
WAUSAU UNDERWRITERS INSURANCE

MFDR Tracking Number
M4-11-3148-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "They continuously deny our claims for bundling. Once our office takes the next step to file a 1st Level Appeal and even sometimes a 2nd Level Appeal they will turn around and pay the claim. In the mist of submitting the claim, when Liberty Mutual receives the claim it is a clean claim and our office feels as though they are using 'Bundling' as a stale tactic not to reimburse the providers within the mandated timeframes."

Amount in Dispute: $1,294.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Foundation Ancillary Services Affiliates, LLC has been appropriately reimbursed for services rendered to [injured employee] for the 10/29/2010 date of service."

Response Submitted by: Liberty Mutual Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2010	95957-TC, 95929-TC, 95928-TC, 95955-TC, 95920-TC x 3, 95925-TC, 95926-TC, A4556 and A4557	$1,294.19	$805.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - X901 – Documentation does not support level of service billed.
   - B291 – This is a bundled or non covered procedure based on Medicare guidelines no separate payment allowed.

- X070 – Letter to follow.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Did the requestor bill in conflict with the NCCI?
2. Is the requestor entitled to reimbursement for CPT codes 95925-TC, 95926-TC, 95928-TC, 95929-TC and 95955-TC?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT codes 95957, 95929, 95928, 95955, 95920 x 2, 95925, 95926, 95861, 99080, A4556 and A4557 rendered on July 14, 2010. The requestor billed the following CPT codes on July 14, 2010; 95929-TC, 95861-TC-59, 99080, A4556, A4557, 95920-TC-59, 95955-TC, 95927-TC, 95925-TC, 95926-TC and 95928-TC. The division completed NCCI edits to identify edit conflicts that may affect reimbursement. The following edit conflicts were identified:

   Per CCI Guidelines, Procedure Code 95957 has a CCI Conflict with Procedure Code 95955. A modifier is not allowed.

   Per CCI Guidelines, Procedure Code 95920 INTRAOP NEUROPHYSIOLOGY TSTG PR HR has a CCI conflict with Procedure Code 95955 EEG NONINTRACRANIAL SURGERY. Review documentation to determine if a modifier is appropriate. The requestor appended modifier -59 to this services.

   The CPT Manual defines modifier 59 as follows: "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

   The division finds that reimbursement is not recommended for CPT code 95957, due to the edit conflict with CPT code 95955 and no modifier is allowed.

   The division finds that the requester's documentation does not support the application of modifier -59 to CPT code 95920, as a result reimbursement cannot be recommended for the one unit of CPT code 95920.

   The requestor seeks reimbursement for HCPCS Level II codes A4556 and A4557. The following was identified:

   HCPCS Level II codes A4556 and A4557 contain status code "P" defined as "P- Bundled/Excluded Codes.

   - If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)
   - If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act."

   As a result, the requestor is not entitled to reimbursement for HCPCS codes A4556 and A4557. The division has not identified edit conflicts for CPT codes 95925, 95926, 95928, 95929 and 95955 as a result; these CPT codes are reviewed pursuant to the applicable laws and rules.

2. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   CPT code 95925 is defined as follows "Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs." The MAR amount is $151.91, therefore, this amount is recommended.

   CPT code 95926 is defined as follows "Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs." The MAR amount is $147.59 and therefore this amount is recommended.

   CPT code 95928 is defined as follows "Central motor evoked potential study (transcranial motor stimulation); upper limbs." The requestor seeks $225.00, the MAR amount is $190.43 and therefore this amount is recommended.

   CPT code 95929 is defined as follows "Central motor evoked potential study (transcranial motor stimulation); lower limbs." The requestor seeks $225.00, the MAR amount is $207.19 and therefore this amount is recommended.

   CPT code 95955 is defined as follows "Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)." The MAR amount is $138.94, the requestor seeks $108.74 and therefore this amount is recommended.

3. Review of the submitted documentation supports that the requestor is entitled to a total recommended reimbursement amount of $805.86.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $805.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $805.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 23, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.